University of York
The York Management School
Working Paper No. 55
ISSN Number: 1743-4041
May 2010

Reluctant Bedfellows or Model Marriage? Postmodern Thinking Applied to Mainstream Public Sector Health Services Research Settings

Martin Wood
University of York

Reluctant Bedfellows or Model Marriage? Postmodern Thinking Applied to Mainstream Public Sector Health Services Research Settings

Abstract

An important mobilisation of postmodernism is as a way of thinking that pays particular attention to the play of differences in human thought and experience. Informed by the Derridean theory of deconstruction, the current discussion critically examines an original piece of health services research undertaken by the author, which aimed to derive propositions about how health service researchers disseminated research information to those in daily practice in the United Kingdom (UK) National Health Service (NHS). The objective is to provide an analytical review of those tacit and oftentimes suppressed, marginalized or hidden, forms of knowledge that may be conveniently overlooked or glossed over in mainstream health services research, which is largely produced by university-based researchers who remain subject to traditional academic pressures. Following a review of the theory and practice of deconstruction, Boje and Dennehy's (1994) specific seven-point 'deconstruction methodology', based on drawing empirical data through bipolar opposite themes, is deployed before concluding with a consideration of the implications of a postmodern analysis of mainstream healthcare practice, policy and organisation settings, which have a central role to play in delivering service improvement in the new financial environment.

Keywords: deconstruction, Derrida, epistemology, health services research, methodology, postmodernism, United Kingdom

Introduction

The term 'postmodernism' has been mobilised in various ways. One such mobilisation is as a cultural 'epoch' (Hassard & Parker, 1999), or a loose collection of 'periodising concepts' (Jameson, 1991: 113; see also, Bell, 1974), describing roughly the post-industrial, transnational and information age. A second mobilisation is as an 'epistemological' shift (Hassard & Parker, 1999) in interest away from all-encompassing concepts toward culturally bound judgements. As a cultural condition, postmodernism offers a critique of social change at a time when we have clearly moved away from a 'modern' era of industrial organisation, Enlightenment science and universal progress (Beck, 1992). In the postmodern era, societies are characterised by weakened ties with traditional social and political alignments and the ruthless efficiency of capitalist market values. The postmodern tenet stems from themes and styles drawn from popular culture – perhaps best exemplified by 20th century American mass-consumer behaviour – to correlate the emergence of a new, post-industrial economic order and new formal features in a society of the media (McLuhan, 1964), or the spectacle (Debord, 1983), or the consumer (Bauman, 1992; Featherstone, 2007), or multinational 'informational' capitalism (Giddens, 1991; Hardt & Negri, 2000). Meanwhile, as an epistemology, postmodernism emphasises the elusiveness of meaning and knowledge. If modernism put its faith in progress, science and rationality, fixed concepts and stabilised meanings, then postmodernism is radically sceptical of the possibility of constructing such an all-encompassing master-system, since the signs of the master-system itself are themselves subject to a continuous process of *de*construction – the prefix '*de*' suggests a constant relation *within* terms, which are always constructed with reference to their opposite. This means that although the postmodern approach places importance on the role of language in defining reality, we cannot always assume we know what words mean (Derrida, 1976; 1978). If we accept

the argument that language is never finally closed or clear in it's meaning, we must also acknowledge our constant struggle to make definitive judgements about reality. A further implication of the postmodern argument, therefore, is that 'reality' (in the objective sense of the word) has been lost, become irrelevant, or that it is, and always has been, an unstable construct fashioned by social discourses whose purposes it serves (Foucault, 1980; Lyotard, 1984).

As a consequence, postmodernism foregrounds the socially constructed nature of the contemporary world, where defining 'reality' involves making judgements about which qualities are relevant to the definition and which are not. For example, compared to the apparent order and orientation social structures and relations of production brought to life and thinking in the 'modern' industrial era, postmodern society leaves many people feeling fragmented, isolated and even 'schizoid' (Deleuze & Guattari, 1983). The power of traditional structures to provide clearly defined roles has diminished nowadays almost to the point of obscurity (Bauman, 1992; Beck, 1992; Giddens, 1991). As a result, people routinely have to deal with an increased number of decisions and choices about their life, their self-identity and other objects of 'reality'. But more importantly, a person's decisions and choices about whom he or she is and how he or she defines him or herself and others (Augé, 1995) are subjective interpretations, since they necessarily depend on the meanings and values he or she brings to the definition. For postmodernism there is no such thing as stable, objective or ordered reality since all 'reality' is defined in this way.

A central focus of postmodern analysis is the insistent deconstruction of the stability, objectivity and order, emphasised in the modern explanatory schema. The current discussion is centrally concerned with this mobilisation of postmodernism as a critical analysis. The aim is to make use of the specific seven-step 'deconstruction process' put forward by Boje and Dennehy (1994: 340) to provide a critical analysis of a conventionally undertaken piece of health services research undertaken in the United Kingdom (UK) National Health Service (NHS)

(_____, 2000). The objective is to provide an analytical review of those tacit and oftentimes suppressed, marginalized or hidden, forms of knowledge, which may be conveniently overlooked or glossed over in mainstream health services environments that have been encouraged for more than two decades to pursue the rigorous implementation of the Taylorist imperative of predictability and *scientific* control over clinical practice (Sackett, Rosenberg, Grey, Haynes & Richardson, 1996).

The current discussion is structured as follows. In the next section, the theory and practice of deconstruction will be reviewed in more detail. In section three the original empirical research project setting, design and methodology are discussed. In section four, Boje and Dennehy's (1994; see also Boje, 1998) specific deconstruction technique is employed as a postmodern methodology to interrogate the strategies in use by health services researchers, as they try to connect health care research information with those in daily clinical practice. Finally, in section five, Boje and Dennehy's (1994) strategy for deconstructing a text is reviewed and the implications of this approach, both for the mobilization of postmodern thinking and for the subsequent report of findings in 'mainstream' health services research settings, are considered.

Deconstruction

The concept of deconstruction is most closely associated with the French poststructuralist philosopher, Jacques Derrida. Derrida's (1976; 1978) thesis comprises an ambitious critique of some of the central figures and cardinal concepts of Western thought: namely Cartesian 'differentiation', Hegelian 'idealism' and Saussurean 'semiology'. His critique demonstrates a distrust of the concepts of the stable sign, the unified subject, fixed identity and truth, which, he

argues, form the central premises of Western language, society and humanity. He is particularly interested to challenge the hegemony of these concepts and to undermine any sense of grounded stability that tends to ossify and restrict our knowledge and hence distort our experiences of reality, proposing instead indefinite play in the field of human experience.

Derridean deconstruction draws critical attention to those subjective and often ephemeral aspects of lived experience, whose indeterminate processes are conveniently overlooked or glossed over. Derrida calls for a 'decentring' of foundationalist attitudes such as 'logocentricism' (Derrida, 1976: 11), as well as a whole range of binary contrasts– inside-outside, subject-object; truth-falsity, etc. (Derrida, 1978) – that have circulated widely in Western thinking and which we use to express our lived experiences. From the Greek, *logos*: to give order and form to the world, logocentrism supports the view that our linguistic ordering and symbolic representing of the world is the transparent source of intended meaning, the stable identity of the sign and the positioning or presence of the subject. That is, the view that the logos or language of the user can mirror reality. Proposing a theory of 'grammatology' (Derrida, 1976) to study writing as opposed to spoken words, Derrida exposes the network of technical conventions and symbolic representations, beyond the grasp of the individual speaker, which mediate attempts to stabilise meaning and value and through which the play of differences within experience inevitably slip through and escape.

He redeploys logocentrism within a transformed framework that makes the hierarchical opposition *between* alleged stable signs untenable. For Derrida, our experiences of reality have no objective meaning or value and lived experience always exceeds our attempts to represent it. Nothing enjoys an original presence, rather a thing 'plays out' in an indeterminate field of slippages and substitutions that always refer it to what it is not. Terms therefore point to something 'other' than themselves, a necessary supplement that is always opposite (Derrida,

1976). Derrida invents the word *différance* – embodying the French verb 'differer': to differ, or disagree in space, and 'defer': to adjourn in time – to illustrate how lived experience cannot be grasped simply by constructing binary opposites, but must always be situated in the instable 'between' of a presence and its *internal* supplement. In other words, human experience is produced by différance *within* terms, half of which is identical with a thought or thing 'that is' and which 'is here', and the other half which is always 'not the thing' and 'not there' – what 'differs from' and what is present by being forever absent, 'deferred'. This inarticulable 'logic of betweenness' (Cooper, 2005: 75), in which terms recreate themselves repeatedly out of each other, marks the place of différance and points to 'a shared space we can never reach but which at the same time seems to originate the specific terms we can specifically identify' (Cooper, 2005: 71).

The Derridean notion of deconstruction clearly rejects the universal methods of Western scientific inquiry. Because the focus is on discourse in a particular social context, a wide range of valid data sources now become the legitimate domain of concern. These may include in-depth/open-ended interviews, electronic mail, focus and discussion groups, field observations, documents, charts, plans, mission statements, job descriptions, working procedures, memoranda and other communiqués. Each of these sources can be used in various ways to lay bare the contradictions and concealed meanings in a 'text'. The notion of a 'text' here refers to the series of concurrent and sequential conversations between people, whether written, spoken or acted, and all their inter-relationships, including what is not written, spoken or acted, and which are infused with meaning.

Practically speaking, deconstruction examines what is left out of a text. It aims to decentre, destabilise and otherwise interrogate the surface or espoused meanings that attempt 'insidiously' (Learmonth, 1999: 1001) to organise and represent lived experience and so to reveal

other possible 'readings'. Deconstruction has been used to 'read' a wide range of cultural, political, economic, and other social texts. In organisation and management studies, for example, Boje (1998) is concerned with how the dominant 'for profit' or 'managerial' ideology of the corporate giant *Nike* excludes access to alternative perspectives on the margin, such as those captured by the everyday stories, myths and beliefs, of Asian women workers. The deconstructive approach has also been developed in public services research (Currie & Lockett, 2007; Currie, Lockett & Suhomlinova, 2009; Ford, 2006; Learmonth, 1999) and in 'critical' healthcare management studies (Ford & Harding, 2007; Learmonth & Harding, 2004). Learmonth (1999) takes a short extract from a management report and explores the unintended messages the text carries. The text is deconstructed focusing particularly on the 'binary opposites' reason and emotion. Learmonth argues the author of the report intended to prioritise reason and to exclude, hide or otherwise marginalize emotion in the text, but in doing so he appears to constitute his role in ways that might be characterised as emotional.

Ford (2006) provides a further example of deconstructive theory in practice through her analysis and discussion of contemporary discourses on leadership identities in a public services organisation. She finds traditional 'macho, individualistic and assertive behaviours' continue to dominate over 'qualities such as empathy, capacity for listening and relational skills and so on', despite the organisational rhetoric suggesting the value of a more 'feminine' set of practices (Ford, 2006: 96). Meanwhile, Ford and Harding (2007) discuss their attempt to destabilise a leadership development intervention in a public sector health services organization by adopting a 'non-' or 'anti-performative' stance to challenge the legitimacy and efficacy of established patterns of thinking and action (Ford and Harding, 2007). Whilst Currie and Lockett (2007: 344) argue how, despite transformational leadership being a 'a buzzword among education ministers' and formal policy makers, attempts by principals of publicly (tax payer) funded schools in the

UK to enact transformational leadership locally prove inconsistent with critical pressures from central government. These pressures quickly turn leaders aspiring to 'transform' their organisations purely into 'technicians' or 'managerial' leaders, 'simply devising a means for achieving mandated purposes' (Currie & Lockett, 2007: pp. 345-365).

Health systems around the world nowadays face similar critical pressures as they aim to deliver service improvements at the same time as confronting severe funding constraints due to the impact of the global recession and shrinking public sector budgets. In health services research, for example, there has been a growth of interest over the last two decades in a model of evidence-based healthcare (EBHC) as a potential way to meet both immediate economic challenges and longer-term service objectives with reduced resources. In the UK, EBHC is a government-endorsed framework that pursues the rigorous implementation of scientific evidence into clinical practice (Sackett et al. 1996). A central tenet is that health services research should be based on an explicit logic of systematically located best evidence, combined with a critical appraisal of the validity and usefulness of its application to practice (Barton, 2000; Haines, 1996).

EBHC is primarily financed through the NHS, and is largely produced by university-based researchers who remain subject to traditional academic pressures (Grimshaw, Shirran, Thomas, Mowatt, Fraser, Bero, et al, 2000; Haines & Donald, 1998; Williamson, 1992; _____, 1998). Gibbons and his colleagues (1994) argue that a broader shift in knowledge production from traditional mode 1 (academically based) towards a novel mode 2 (socially distributed) system is evident in health services and other applied research settings. Mode 1 follows the traditional model, whereby knowledge production occurs through an academic agenda, with knowledge stocks guarded by 'elite gatekeepers' (Tranfield & Starkey, 1998) and dissemination occurring downstream of knowledge production. Mode 2 offers a more

socially distributed account, whereby knowledge is produced in the context of application and research capacity is transdisciplinary driven and extends beyond traditional academic institutions in a more socially and politically accountable knowledge production process (Pettigrew, 1997). The prediction of an intermode shift is contested, however. Whitley (2000) argues mode 1 retains great defensive power. Huff (2000) argues mode 2 carries intellectual dangers of its own; it is too pragmatic, uncritical and unlikely to create a generalisable knowledge stock. ____ (2002) notes how mode 2 approaches, while recognising the stronger interactivity of those producing and using knowledge, still maintain a correspondence view of knowledge in which spatially discrete communities (academics and practitioners) are urged to accurately embody the demands of the production-to-use orthodoxy.

Clearly, a variety of deconstruction techniques could be used in reading and evaluating organisational texts. In the current discussion Boje and Dennehy's (1994) specific seven-step deconstruction process will be adopted. This is because it can be used specifically to highlight excluded, hidden or otherwise marginalized 'voices' in the organisational text of health services research and also to 'play' with the 'characters', 'plots' and 'stories', in the field. The seven components of the process are reproduced from Boje and Dennehy (1994: 340) and briefly defined below:

1. Define the dualities – who or what is at opposite ends in the story?
2. Reinterpret – what is the alternative interpretation to the story?
3. Rebel voices – deny the authority of the one voice. Who is not being represented or is under-represented?
4. Other side of the story – what is the silent or under-represented story?
5. Deny the plot – what is the plot? Turn it around.

6. Find the exception – what is the exception that breaks the rule?
7. What is between the lines – what is not said? What is the writing on the wall?

Following this review of the theory and practice of deconstruction, and before deploying Boje and Dennehy's (1994) specific seven-point methodology, it is helpful first to briefly outline the settings, design and methodology of the original empirical research project (_____, 2000).

Original Empirical Research Settings, Design and Methodology

Design of the Original Research Project

The original research project began with exploratory case studies to derive propositions about how health service researchers disseminated research information to those in daily practice. These were supplemented by a postal survey, which tested early propositions and other contemporary issues drawn from the health research and management literatures against a wider population. Four research groups were recruited for the qualitative case studies. These were selected as matched pairs according to whether they displayed explicit attention to development as well as 'pure' research. The four case studies utilized a two-stage methodology. Stage 1 provided a general overview of the investigators' everyday work as well as the size and scope of the scientific, social, and professional networks in which they were embedded. This was intensified in Stage 2 through microanalysis of the investigators' role occurring in a particular research programme in each setting.

The final case-study selection yielded a general two-by-two matrix incorporating medical, surgical, nursing and professional functions and more or less explicit attention to research development. Table 1 illustrates the basic character of the four original case studies, together with the relationship between functions and attention to development in terms of disciplinary context and the preferred research mode.

INSERT TABLE 1 ABOUT HERE

Original Data Collection and Analysis

Qualitative and quantitative methodologies were mixed. A total of 70 semi-structured interviews were conducted, taped and verbatim transcribed, and full field notes were written up to facilitate full and accurate content analysis. Two semi-structured interview schedules were designed, one for each of the case study stages and applied uniformly across cases. The survey instrument was posted to a non-probabilistic sample of 376 research directors/senior researchers in the sponsoring NHS region. The final response rate achieved was 53% (n=199).

The qualitative data were coded using a frame derived through content analysis, which produced empirically grounded themes across the four cases. These themes reflected the complex interplay between the ideas, opinions and values expressed by the people being studied, and the norms, conventions and influences apparent upon them. Main occupational groups were used to break down survey responses as follows: academic, medicine, nursing, management, and other professional areas. This range of occupational groups was purposively analysed to facilitate exploration of similar or different results across different health services research stakeholders, who might reveal distinctive opinions within the survey.

Original Conclusions

The original findings of the four case studies and survey data suggested four overarching themes: (1) that there was a mix of mode 1 and mode 2 in university based health services research in the UK, but that any mode 2 pattern was only partially evident; (2) health care researchers faced a mode 1 pull back to their host academic institutions and disciplines as well as a mode 2 pull to the field; (3) the basic disciplines retained greater defensive power than Gibbons et al (1994) suggested, indeed, mode 1 outputs were highly valued by some (though not all) research consumers as a sign of quality and a health services researcher had to work in both modes simultaneously; (4) this intermode balancing was a dilemma, especially for research group leaders who undertook major networking (as well as scientific) tasks.

Discussion

Each of the seven components of Boje and Dennehy's (1994) deconstruction process will now be deployed to provide a critical analysis of the strategies in use by the health services researchers in the original research project as they tried to connect health care research information with those in daily clinical practice. Acronyms appearing in parenthesis in quotations and text (HSC/HDP, etc.) refer to the original code categorisations utilized in the original data analysis and identify individual case studies/micro-analyses respectively. These are uniformly applied throughout subsequent sections to identify the source of direct quotations.

Define the dualities

The original data suggest several pairs of binary opposites, which stand in hierarchical relationship, are in use within health services research. For Derrida, all of Western thought forms

dualities in which one term of the binary is given primacy and legitimacy, while our knowledge and hence experience of its opposite term is simultaneously suppressed, marginalized or effaced (Derrida, 1976). Health services research, like most public and private sector organisations is essentially a social and interactive space that seems to originate the binary opposites we can specifically identify. In the current discussion, these include: evidence-practice, corporate-individual, analysis-intuition, art-science, order-disorder, automation-autonomy, social-technical and cause-effect, and many more.

Having made a list of the bipolar terms used in the original data, even if only one of the specific terms of the binary is mentioned – as what is *not* written, spoken or acted is also infused with meaning – the objective now is to explore the dualities in order to see how the indefinite play latent in the system can be rediscovered (Cooper, 2005). In order to give new voice to those tacit terms of the binary, which may have been conveniently overlooked or glossed over, we must find ways to create and restore the very possibilities for an essentially unmarked (undivided) interactive space. As a start, we may choose to write the relationship between the binary opposites in terms of *both and* rather than *either or* relationships: for example, *both* knowledge *and* practice and art *and* science, and so on. It is an attempt to show the incomplete and continuous becoming between the terms, rather than the severed and mutilated condition that only sees one term but not the other. On this view, bipolar terms are seen as 'temporary stabilisations' (Cooper, 2005: 61), rather than as stable and fixed things.

Reinterpretation

A second place to begin with deconstruction is to reinterpret where the rhetoric of a text does not live up to its stated expectations, visions, and philosophy, or is even the opposite of what it says it does. One reinterpretation approach is to look at what Derrida (1976) terms the logic of

'supplementarity'. Derrida coined the term supplementarity to better undermine the idea of the stability of our conceptual structures and the assumed origin and essential nature of things, which he says are no more than a 'myth' of logocentricism. Instead, he argues the very instability of our conceptual structures and the indefinite play between assumed origins and the essential nature of things always harbours a supplement that makes visible a critical distancing between our conceptual structures and the assumed origin and essential nature of things. Like the relationship between an 'opposing strategy' that is a 'hindrance', 'stumbling block', or 'point of resistance' to the machinery of power and yet makes that power possible (Foucault, 1978: 101), supplementarity fills the inevitable gap caused by the indefinite play that is the open 'text' of a thing.

Health services researchers will sometimes 'supplement' formal texts in various ways. One way is to write alternative interpretations using the same text's particulars. EBHC is an example of a formal text, whose pursuit of the rigorous implementation of scientific evidence into clinical practice (Sackett et al. 1996) supports a 'hierarchy of evidence' with quantitative methods – usually in the form of randomised controlled trials – at the top and qualitative studies and 'opinion' at the bottom. The EBHC model is therefore a good example of an attempt at 'intermode' research in healthcare services. Nonetheless, any mode 2 patterns are mostly 'bottom-up' and mode 1 outputs are, in general, more highly valued.

It is possible to 'read' EBHC as a 'text' and not as a document with a stable conceptual structure, assumed origin and essential nature. In the in the original data, health services researchers were asked what 'evidence' meant in the context of evidence based healthcare. The following are just a sample of the responses:

'The gold standard has to be the randomised trial.'

> ‘The biggest weakness in clinical evidence is the random control trial as the prime method for discovering anything … No other science I know relies on the RCT and to me this is crazy.’

> ‘Its bits of research that support what I’m actually doing. If I was totally honest about it I often look for the research that backs me up and ignore the bits that go against me. I suspect that, although I cringe at admitting it, if you found a lot of honest clinicians they do exactly the same.’

> ‘I think what you look for as evidence is trends rather than one seminal paper … evidence is an opinion supported by lots of other opinions, so that you get a general theme rather than a hard fact.’

Rather than confirming the institutional prescriptions of centralized EBHC guidelines and protocols, these excerpts actually suggest critical reinterpretations that undermine the idea of the stability of our conceptual structures and the assumed origin and essential nature of things. Indeed, rather than achieving the closer supervision of individual work performance by limiting clinicians’ traditional freedom to act, the excerpts actually set out a series of ‘lacks’ or ‘deficits’ in the EBHC model. The respondent’s reinterpretations effectively ‘supplement’ the EBHC model’s lacks in several ways. For example, it’s over reliance on science: ‘The biggest weakness in clinical evidence is the random control trial’, and it’s over emphasis on diffusion and technology transfer: ‘you look for as evidence is trends’, and ‘I often look for the research that backs me up and ignore the bits that go against me’, and so on.

Rebel Voices

When the dualities are examined and reinterpreted, what seems to be an unproblematic set of shared and consistent priorities, values and assumptions, is revealed to be a unitary (usually managerial) voice that speaks for all other voices on the requirements of purpose, strategy and outcome measures (Boje, 1998). The task here is to deny the authority of the one voice and to investigate what voices are not being expressed and which voices are subordinate or hierarchical to other voices (Boje & Dennehy, 1994).

In the original research project, the government-endorsed EBHC model is an important voice that keeps other professional proclivities at bay and bound to the centre. Boje and Dennehy (1994: 340) coin the phrase 'rebel voices' as a way of including the complex and often contradictory cluster of counter activities, attitudes, behaviours, values and beliefs of health care researchers, whose voices are oftentimes suppressed, marginalized or silenced altogether. For example, in a research environment governed by the audit culture of UK universities, the cardiovascular laboratory is required to compete on the basis of peer-reviewed grants and high impact publications in good journals. As the following respondent puts it:

> 'The more your publications are in good journals the more is the likelihood of having good offers from funders ... everything is credited, everything is numbered, everything is quantified. The [greater] the quality of your work, the more likely [it is] that you can carry on surviving.' (CR/04)

Here, the dominant and official story of continuing finance and the observed criteria by which managers allocate rewards and status ('everything is numbered … quantified') seems to

have successfully co-opted the respondent whom appears resigned to the 'correct' way of thinking and behaving in relation to the problem of 'surviving'. Dominant and official stories can often be successful in 'manufacturing' agreement intended to facilitate managerial control and coordination by regulating and importantly routinising desired behaviours such as 'quality' and 'value added' in employees. Nonetheless, dominant and official stories do not always square with rebel voices. Here the requirement for accountability and the highly competitive tendering environment are both singled out for criticism in the health informatics case:

> 'You fashion the project according to the money and how much you can do but it is not completely satisfactory ... there is a sense you feel that trying to do things and meet deadlines and to deliver when there is not huge amounts of resources.' (HI/05)

The rebel voice appears again in the frustrations of one cardiovascular researcher who draws attention to the dichotomy between normative input/output measurements and the reality of making a scientific contribution:

> 'You design a piece of research that would bring you money, that academically or scientifically is very poor, but that brings a lot of money ... and then you design a piece of research that is scientifically very important and would give you strong publications ... my previous professor used to call it prostitution, because you do it to bring money in. The other one is real science, it is exciting, but nobody wants to fund it.' (CR/05)

Clearly, the single voice that speaks for all other voices can only do so as long as those others, in whose name it speaks, remain silent (Callon, 1986). However, the monolithic authority

of the dominant and official voice is quickly problematised as soon as unorthodox and countervailing views are heard.

Other Side of the Story

Another deconstructive technique is to spotlight the usually excluded and repressed side of a story by positing reversals in the hierarchy of the dualities. This reversal allows exploration of the play of differences behind each of the binary terms (Boje & Dennehy, 1994). The differences allow us to confront and even reject any centred, totalising theory presented in the formal story. For example, we can explore how the EBHC fetish of scientificity, diverges from its 'critical' academic conception (____, 2002; _____, 2003; _____, 1998). We can explore how the dominant ideology of the separation of knowledge production from its practical application, in which good research is assumed to 'speak for itself' (PC/06), is subtly 'sidestepped' or straightforwardly overturned. Research does not speak for itself but neither do research findings sit and wait for someone to pick them up and use them. Rather, there is increasing acceptance of the need to rethink the nature of health services research itself. A point exemplified by the following excerpt:

> 'People call it dissemination, it is not dissemination; it is much more about development ... I think there are things about the importance of the networking and the inter-personal relationships and in getting research listened to, but it is not just enough to give papers, there is something about actually needing to engage with people more.' (HSC/HDP/06)

Words like 'developing', 'networking', 'relating' and 'engaging', give voice to a shift in interest from the official production-to-use orthodoxy, to the pull-of-the-field in healthcare research.

Deny the Plot

According to the storytelling turn in organisation and management studies (Boje, 1991; 1995; Czarniawska, 1998; Gabriel, 2000; Letiche, v Boeschoten & Dugal, 2008), stories narrate an organisation in ways that suggest one or more formal plots, scripts, scenarios, recipes and morals, which we can turn around. For example, the 'science push' plot of EBHC is a thin veil for another plot. The EBHC model is also an ideological manifestation of the Taylorist imperative of predictability and 'scientific' control: top-down clinical guidelines and protocols, the separation of planning and execution and the closer supervision of the traditional clinical 'freedom' to prescribe.

Denying the official plot leaves room for a critical assessment of the EBHC model and its assumptions about the dissemination of knowledge and changing practice. Despite various criticisms, the arguments and ideological implications of Rogers' (2003) simple top-down diffusion of innovations model has had a major influence on EBHC implementation. Yet, empirical work by Ferlie and colleagues (2005) and _____ (1998) stresses strong networks of social, technical and political associations within different professional groups, which inhibit the spread of new work practices. And we can present other interpretations that deny EBHC's scripting and depicting of reality is the only ways to grasp or plot these actions, characters, and ends. In the following excerpt, for example, competition for external finance is the powerful driver to modify the attitudes and actions of healthcare researchers and not the ideological propaganda of EBHC itself,

> I think there is a fundamental issue around actually how we see the research enterprise … part of me loves that kind of pure research world if you like, which would not have to do

> any fieldwork at all. But it is almost as though that would not answer any of the questions that people are likely to fund me to do. (HSC/07)

Similarly, a primary care researcher reported:

> You have got to know what the flavour of the month is. You have got to know whether you have a fair chance of influencing whoever is going to be assessing it. All the wrong reasons. (PC/03

Denying the official EBHC plot reveals at least two different story lines: a 'from on-high' hegemony that is the sole arbiter for influencing the opinions or actions of individual researchers; and the view 'from below', which is suspicious about the formers motivations, 'propaganda practices' (Boje, 1998) and hence quality.

Find the Exception

EBHC suggests two models of knowledge production and dissemination. First knowledge is created and controlled by academic disciplines and that diffusion is embedded in academic communities of *production* (mode 1). Second, the explicit logic of research evidence is combined with consideration of practical needs, so that research problems are framed in the context of *application* (mode 2). Despite this apparent bifurcation, however, the formal plot of EBHC retains scientific evidence and clinical practice either as *separate* categories (e.g. Sackett et al., 1996), or as a two-way process, in which the unit of analysis remains the binary opposites themselves, or the one-to-one *correspondence* between the two terms (_____, 2003).

For example, commentators routinely draw attention to a large and problematic 'gap' between clinical practice and the findings of research (Haines & Donald 1998; Sheldon, Guyatt & Haines, 1998; Straus & Sackett 1998) and to the methodological concern of tracking down best evidence and critically appraising the validity and usefulness of its 'application' to practice (Haines, 1996).

The duality in each case is that evidence is *not* practice. The specific terms we identify are considered as simply flowing through disciplinary consensus and correspondence and so remain outside of and importantly 'above' the social dynamic. As a consequence, both mode 1 and mode 2 patterns assume a causal relationship between clinical practice and the scientific evidence that sustains it. Also, the philosophical consideration mode 1 and mode 2 patterns give to scientific evidence and clinical practice, as binary opposites, only understands relations *between* terms and so loses any sense of the indefinite play of evidence and practice *within* relations

Nonetheless, it is possible find exceptions, however extreme or absurd, which break the rule, do not fit the recipe, and which escape the strictures of the principle (Boje & Dennehy (1994). In the original data, one health services researcher asked if what she was doing was research or development (HSC/02), while another pointed out that 'there is just always a tension between the research side and the action side of it' (HSC/03). The irreducible 'logic of betweeness' (Cooper, 2005: 75) that runs through Derrida's concept of différance is captured most aptly in the following short, original excerpt:

> 'The theoretical and the practical are perhaps not quite as distinct as they might appear to be.' (HSC/07)

Now the EBHC claim that scientific evidence and clinical practice are binary opposites is no longer exclusive; it does not exercise universal control over the knowledge production and

dissemination research agenda. Instead, another possible 'reading' is revealed. An exception has been pointed out that makes a whole new turn in research possible (see, for example, Cooper's (2006) introduction to the concept of *relationality* in organisation studies and also ____'s (2005) application of the notion in relation to leadership).

What is Between the Lines?

The linguistic turn that deconstruction brings to organisation and management studies exposes the focus on language as the mediating influence in the construction of alleged stabilised meaning. Derrida's typographical framework of 'grammatology' (Derrida, 1976) proposes that the appearance of any stabilised meaning must immediately be placed 'sous rature' (usually translated as 'under erasure'). Being under erasure signifies that a thought or thing is inaccurate yet necessary, as in the always already absent presence of différance. Technically, the thought or thing under erasure is deleted (X) in such a way that both the deletion and the thought or thing crossed through remains legible. Letting both the deletion and the thought or thing stand is important for Derrida because it exposes the risk of forgetting both the indefinite play of thought and experience and the reductive belief that either the deletion or the thought or thing can be simply 'liberated' toward a fixed end – the thought or thing as that which straightforwardly 'is' or 'is not'.

The implication of this insight is that we should try to 'read' what is between the lines of the 'natural' relationships between familiar thoughts and things. In this way, we can attempt to decentre and destabilise dominant characters and scenarios, and to look for possible points of departure from formal stories and plots. The idea is that we should attempt to take a context-sensitive approach to elements of the situational-text and certainly not to adopt a neo-positivist position (Alvesson, 2003), in which we aim to establish a context and bias free truth about reality

'out there'. To the contrary, nothing speaks for itself (Denzin, 1994) and with this in mind, we are able quite legitimately to confirm or challenge, interpret and respond to the research sources, perhaps by examining how a particular character orients their talk, or thinking about what is not said in formal a meeting or interview, or by expressing an opinion of our own. In this way we might focus on the rules, expressions and accepted practices that characters generally pay attention to, or to the pauses, gaps, choices of words and where they are used in particular conversations. In interview settings, respondents frequently and rhetorically state: 'you know that part of the story.' What parts of the story are we filling in? What are the 'blanks'? What is said by not being said – the absent presence?

All of above imply the need for 'reflexivity' and an awareness of our inner convictions, how they contribute to ongoing meaning construction and the effect of these on the processes and outcomes of the research itself. For example, Learmonth (1999) ends with some 'reflexive reflections', both on his analysis of the examined executive report, the author of which Learmonth is 'fairly well acquainted', but also of the 'rationality that typifies conventions in academic publishing' (viz. the neo-positivist aim to communicate truthful, context-free – or at least 'context-thin' knowledge) (Learmonth (1999: 1010). To this end, Learmonth offers a refreshing auto-deconstruction that not only problematises his assumed 'detached' analysis, but also his own 'personal' responses, first as 'mainstream' ex-NHS manager and second as 'critical' scholar.

With this idea mind, I offer some reflective and reflexive comments concerning my own context-sensitivity, potential for discrimination and personal bias in the original empirical research project. First, although our epistemological stance was (and is) clearly stated, we did not seek to question and perhaps reframe it as the original empirical proceeded. At the time of the original research project, this shortfall undoubtedly had something to do with the pressure, in my

own case, for a new-career researcher to report the findings of a time-limited project in a manner acceptable to a dominant funder with high market power, as well as the need to meet the expectations of a senior colleague and academic criteria for publishing in a top-rated, global business school. In what alternate ways could I have turned in my report? Furthermore, how might a report drawing attention to more reflective and reflexive concerns have been validated in a competitive funding environment where research is usually conducted according to commissioners' specifications rather than being investigator-led? Finally, returning to Pettigrew's (1997) comments on mode 2, in the current academic research environment, whilst it might always be possible to conduct research that is both socially and politically accountable, it might not always be expedient to do so and current power imbalances in the researcher-funder relationship must be acknowledged.

Conclusions

Deconstruction involves the recognition that dominant or 'managerial' ideologies should not be seen as authoritative interpretations of organisational activities or texts. It also implies that analysis cannot provide authoritative interpretations either. To seek to do so is to run the risk of forgetting the indefinite play of lived experience or believing that exchanging an old ideology for a new one stabilises the play of differences within experience. While deconstruction can be a political act that opens up the space for new meanings and engagement with dominant ideologies it is important to avoid the presumptuous fixing of an opposite and yet equally centred totalising theory. In deconstructing dominant ideologies the goal is not to defeat or overcome them, but to explore how they are themselves subject to slippage and indeterminacy, as hitherto excluded,

hidden or itinerant themes escape and proliferate from the centre in ways that cannot be re-appropriated by a stable power.

The current discussion deployed the seven approaches put forward by Boje and Dennehy (1994) in their postmodern 'deconstruction process' to provide a critical analysis of the findings from an original empirical research project that sought to explore how health service researchers disseminated research information to those in daily practice, in a key area of UK government-endorsed healthcare policy (_____, 2000). Using Boje and Dennehy's (1994) techniques, based on drawing the empirical data through bipolar opposite themes before reinterpreting them, telling the other side of the story, reading between the lines, and so on, a plausible story has been (de)constructed that undermines the main narrative of the aforementioned healthcare policy and allows the 'bottom up' voices of health service researchers to slip through and be heard.

In political terms postructuralism is highly effective at undermining binary hierarchies. It shifts critical attention away from objective organisational and formal policy factors as the premier force behind organisational activities and outcomes and emphasises the multiplicity of embedded and contextual experiences, meanings and values that individual members bring with them. This means that the strategies used by health services researchers to try and connect health care research information with those in daily clinical practice, cannot be simply explained in terms of traditional models of knowledge production, but rather in terms of the indefinite play in the field of human experience.

In personal terms, it would have been possible methodologically to conduct this critical analysis in many different ways and from any one of a number of epistemological stances. By writing a deconstructive account I am also writing about the effects of my own thoughts and attitudes on the types of knowledge I have sought to capture and use. I chose this particular

approach because it has not been adopted widely in the analysis of health policy and management and because engaging in deconstructive research is a political act that reflects my own concreteness of being in the world, as a political subject, with the capacity (privilege) to challenge the cosy image of functional relationships within organizations – a position Iwas unable or unwilling to exploit in the original research project. In conclusion, the current discussion clearly cannot be seen as an 'authoritative' analysis, or claim to have found the 'best way' of carrying out research, Nonetheless, the foregoing suggests the dominant 'managerial' ideology of mainstream healthcare practice, policy and organisation must actively listen to and explore the daily reality of organisational members and alternative perspectives on the margin, rather than rely on purely technicist interventions such as EBHC. In the end, it is this simple but powerful insight that provides the possibility for a postmodern approach in public sector health services research settings.

References

Alvesson, M. (2003) Beyond neo-positivism and localism: A reflective approach. *Academy of Management Review*, 21, 1, 13-33.

Augé, M. (1995) *Non-places: Introduction to an anthropology of supermodernity*. London: Verso.

Barton, S. (2000) Which clinical studies provide the best evidence?' *British Medical Journal*, 321, 29 July, 255-256.

Bauman, Z. (1992) *Intimations of postmodernity*. London: Routledge.

Bell, D. (1974) *The coming of post-industrial society: A venture in social forecasting*. London: Heinemann.

Beck, U. (1992) *Risk society: Towards a new modernity*. Trans. M. Ritter. London: Sage.

Boje, D.M. (1991) Organizations as storytelling networks: A study of story performance in an office supply firm. *Administrative Science Quarterly*, 36, 106-126.

Boje, D.M. (1995) Stories of the storytelling organization: A postmodern analysis of Disney as Tamara-land. *Academy of Management Journal*, 38, 4, 997-1035.

Boje, D.M. (1998) Nike, Greek goddess of victory or cruelty? Women's stories of Asian factory life. *Journal of Organizational Change Management*, 11, 6, 461-480.

Boje, D.M. & Dennehy, R. (1994), *Managing in the postmodern World: America's revolution against exploitation*. Dubuque, IA: Kendall/Hunt.

Bowling, A. (1997) *Research Methods in Health*. Buckingham, Open University Press.

Callon, M. (1986) Some elements of the sociology of translation: Domestication of the scallops and the fishermen of St Brieuc Bay. In J. Law (Ed.) *Power, action and belief: A new sociology of knowledge*. London: Routledge.

Cooper, R. (2005) Relationality. *Organization Studies*, 26, 11, 1689-1710.

Cooper, R. (2006) Making present: Autopoiesis as human production. *Organization*, 13, 1, 59-81.

Currie, G. & Lockett, A. (2007) A critique of transformational leadership: Moral, professional and contingent dimensions of Leadership within public services organizations. *Human Relations*, 60, 2, 341-370.

Currie, G., Lockett, A. & Suhomlinova, O. (2009) Leadership and institutional change in the public sector: The case of secondary schools in England. *Leadership Quarterly*, 20, 44, 604-616.

Czarniawska, B. (1998) A narrative approach to organization studies. *Qualitative Research Methods Series* (Vol. 43). Thousand Oaks, CA: Sage.

Debord, G. (1983) *Society of the spectacle*. Detroit: Black and Red.

Denzin, N.K. (1994) *The art and politics of interpretation*. In N.K. Denzin & Y.S. Lincoln (Eds.) *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Derrida, J. (1976) *Of grammatology*. Trans. G.C. Spikak. Baltimore and London: The Johns Hopkins Press.

Derrida, J. (1978) *Writing and difference*. Trans. A. Bass. London: Routledge.

Deleuze, G. & Guattari, F. (1983) *Anti-oedipus: Capitalism and schizophrenia*. London: Continuum.

Featherstone, M. (2007) *Consumer culture and postmodernity*. 2nd Edn. Los Angeles and London: Sage.

Ferlie, E. & Wood, M. (2003) Novel modes of knowledge production? Producers and consumers in health services research. *Journal of Health Services Research and* Policy, 8, 4 (Suppl. 2), 51-57.

Ferlie, E., Fitzgerald, L., Wood, M. & Hawkins, C (2005) The (non) spread of innovations: The mediating role of professionals. *Academy of Management Journal*, 48, 1, 117-134.

Ford, J. (2006) Discourses of leadership: gender, identity and contradiction in a UK public sector organization. *Leadership*, 2, 1, 77-99.

Ford, J. & Harding, N. (2007) Move over management : We are all leaders now? *Management Learning*, 38, 5, 475-493.

Foucault, M. (1978) *The will to knowledge: The history of sexuality 1*. London: Penguin.

Gabriel, Y. (2000) *Storytelling in organizations: Facts, fictions and fantasies*. Oxford: Oxford University Press.

Gibbons, M., Limoges, C., Howotny, H., Schwartzman, S., Scott, P. & Trow, M. (1994) *The new production of knowledge*. London: Sage.

Giddens, A. (1991) *Modernity and self-identity: Self and society in the late modern age*. Oxford: Polity.

Grimshaw, J., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L. et al. (2001) Changing provider behaviour: an overview of systematic reviews of interventions. *Medical Care*, 39, 8 (Suppl. 2), 112-45.

Haines, A. (1996) What is evidence based healthcare?' *Proceedings of the London Medical Sociology Group*, The role of 'consumers'/users in evidence based healthcare. London, 13 March.

Haines, A & Donald, A. (1998) Making better use of research findings. *British Medical Journal*, 317, 72-75.

Hardt M. & Negri, A. (2000) *Empire*. Cambridge, MA and London: Harvard University Press.

Hassard J. & Parker, M. (Eds.) (1999) Postmodernism and organizations. London: Sage.

Huff, A. (2000) Changes in organisational knowledge production. *Academy of Management Review*, 25, 288-293.

Jameson, F. (1991) *Postmodernism, or, the cultural logic of late capitalism*. Durham, NC: Duke University Press.

Learmonth, M. (1999) The NHS manager: engineer and father? A deconstruction. *Journal of Management Studies*, 36, 7, 999-1012.

Learmonth, M. & Harding, N. (eds.) (2004) *Unmasking health management: A critical text*. New York: Nova.

Letiche, H., v Boeschoten, R. & S. Dugal, S. (2008) Introduction: Special issue on storytelling. *Journal of Organisational Change Management*, 21, 5, 532-654.

McLuhan, M. (1964) *Understanding media: The extensions of man*. London: Routledge.

Pettigrew A. (1997) The double hurdles for management research. In D.S. Pugh & T. Clark (Eds.) *Advancement in organizational behaviour*. London: Ashgate.

Rogers, E.M. (2003) *Diffusion of innovations*. 5th Edn. New York and London: Free Press.

Rosenberg, W. & Donald, A. (1995) Evidence based medicine: An approach to clinical problem solving. *British Medical Journal,* 310, 29 April, 1122-1135.

Sackett, D.L., Rosenberg, W.M.C., Grey, J.A.M., Haynes, R.B. & Richardson, W.S. (1996) Evidence based medicine: What it is and what it isn't'. *British Medical Journal,* 312, 71-72.

Sheldon, T.A., Guyatt, G.H. & Haines, A. (1998) When to act on the evidence. *British Medical Journal,* 317, 139-142.

Tranfield D. & Starkey, K. (1998) The nature, social organisation and promotion of management research: Towards policy. *British Journal of Management*, 9, 341-353.

Williamson P. (1992) From dissemination to use: management and organizational barriers to the application of health services research findings. *Health Bulletin*, 50, 78-87.

Whitley R. (2000) *The Intellectual and social organisation of the sciences*. 2nd Edn. Oxford: Oxford University Press.

_____ (2002)

_____ (2005)

_____ (2000)

_____ (2003)

_____ (1998)

Table 1: Original Case Study Selection

Setting	Base Discipline	Context	Research Mode
University based Health and Social Care research (HSC)	Nursing	Practical, intuitive and vocational	Facilitative, democratic and action linked model; emphasis on practical change
University based Primary Care research (PC)	General practice	Growth of sector; emphasis on equity and cooperation	Collaborative links and relationships
Teaching hospital based Health Informatics research (HI)	Professional	Driven by emergence of new technologies and uncertainty about human / technology solutions	Multidisciplinary and multinational; partnerships and alignment
University based Cardiovascular Research (CV)	Surgery	Priority driven; emphasis and increasing grant support for RCTs	International presence; collaborative and multi-centre investigations